their information without jumping through these hoops. My bill is a commonsense solution that updates an antiquated system.

Mr. Speaker, I thank Chairman TAKANO and members of the House Veterans' Affairs Committee for their leadership in bringing this bill to the floor, and I urge my colleagues to join me in voting ''aye'' on H.R. 5916.

HONORING JOHN TREES

(Mr. RODNEY DAVIS of Illinois asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RODNEY DAVIS of Illinois. Mr. Speaker, I rise today to honor John Trees.

Mr. Trees lived in Springfield, Illinois, and was the loving husband to our own district office's Candice Trees. On September 28 of this year, they would have celebrated 48 years of marriage.

John was a proud veteran of the U.S. Air Force, serving during the Vietnam war. After his years of service, John went on to become a skilled laborer and accomplished carpenter.

Once retiring from the Illinois Department of Transportation, John had more time to do what he loved. Combining his love of food and serving others, John started his own catering business aptly named Two Drunks in the Dark Catering.

He truly enjoyed spending time with his wife, three daughters, and five grandchildren. Going on yearly trips to St. Louis Cardinal games or attending his grandchildren's sporting events were just a few things ''Papa John'' loved to do.

John would be the first to lend a hand and always had a welcoming door at his home. John was always great at providing advice and giving direction to those who needed him the most.

We honor John today, and I send my deepest condolences to Candice and the entire Trees family during this very difficult time.

FAMINE, BLACKOUTS, AND RATIONING

(Mrs. MILLER of Illinois asked and was given permission to address the House for 1 minute.)

Mrs. MILLER of Illinois. Mr. Speaker, by using diesel-powered equipment, nitrogen, and other fertilizers, American farmers feed our Nation and are the number one exporter of food worldwide.

My fellow farmers and I are alarmed because Joe Biden and his green bad deal team are in the process of creating a food crisis.

Radical leftists will destroy farms, especially family farms, with attacks on fertilizer and livestock. The leftists are pushing to replace the farmland we need for food with solar panels that are terrible for the environment and made in China.

Without farms, people starve. Radical leftists are causing famine, blackouts, and rationing in other countries. We cannot let them control our food production.

□ 1215

ELECTING MEMBERS TO CERTAIN STANDING COMMITTEES OF THE HOUSE OF REPRESENTATIVES

Mr. JEFFRIES. Mr. Speaker, by direction of the Democratic Caucus, I offer a privileged resolution and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 1347

Resolved, That the following named Members be, and are hereby, elected to the following standing committees of the House of Representatives:

COMMITTEE ON APPROPRIATIONS: Mr. Morelle.

COMMITTEE ON ARMED SERVICES: Mr. Ryan of New York, to rank immediately after Ms. Strickland.

COMMITTEE ON NATURAL RESOURCES: Mrs. Peltola, to rank immediately after Ms. Stansbury.

Mr. JEFFRIES (during the reading). Mr. Speaker, I ask unanimous consent that the resolution be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

The resolution was agreed to.

A motion to reconsider was laid on the table.

IS CONGRESS DOING THEIR JOB

(Mr. CAWTHORN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CAWTHORN. Mr. Speaker, the purpose of this institution can be synthesized into one word—''represent.'' But can we, as a hallowed and time-honored body truly sit here in the sacred Chamber and say with straight faces that we are fulfilling this calling?

Our woes as a Nation beset us upon every side, and this body has through inaction or, frankly, malicious action, made many crises worse. At the beginning of this Congress our border was in shambles. Can we honestly say the situation has improved even slightly?

At the start of 2021 our economy was teetering. Today the smog and dust of collapse have yet to settle. Today we are weaker domestically, and frighteningly vulnerable internationally. China rises, Russia marches, the Middle East implodes, and this body sits on its hands and names post offices.

Hear this: America cannot be saved through legislation. Men and women of virtue and value must rise to alter the very culture of our Nation. Christ, not Congress, will be what saves this country.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or if the vote is objected to under clause 6 of rule XX.

Any recorded votes on postponed questions will be taken later.

CONSENSUS CALENDAR

The SPEAKER pro tempore. The Chair announces the Speaker's designation, pursuant to clause 7(a)(1) of rule XV of H.R. 3173, as the measure on the Consensus Calendar to be considered this week.

IMPROVING SENIORS' TIMELY ACCESS TO CARE ACT OF 2022

Ms. DELBENE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3173) to amend title XVIII of the Social Security Act to establish requirements with respect to the use of prior authorization under Medicare Advantage plans, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3173

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Seniors' Timely Access to Care Act of 2022''.

SEC. 2. ESTABLISHING REQUIREMENTS WITH RESPECT TO THE USE OF PRIOR AUTHORIZATION UNDER MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(o) PRIOR AUTHORIZATION REQUIREMENTS.—

''(1) IN GENERAL.—In the case of a Medicare Advantage plan that imposes any prior authorization requirement with respect to any applicable item or service (as defined in paragraph (5)) during a plan year, such plan shall—

''(A) beginning with the third plan year beginning after the date of the enactment of this subsection—

''(i) establish the electronic prior authorization program described in paragraph (2); and

''(ii) meet the enrollee protection standards specified pursuant to paragraph (4); and

''(B) beginning with the fourth plan year beginning after the date of the enactment of this subsection, meet the transparency requirements specified in paragraph (3).

''(2) ELECTRONIC PRIOR AUTHORIZATION PROGRAM.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the electronic prior authorization program described in this paragraph is a program that provides for the secure electronic transmission of—

''(i) a prior authorization request from a provider of services or supplier to a Medicare Advantage plan with respect to an applicable item or service to be furnished to an individual and a response, in accordance with this paragraph, from such plan to such provider or supplier; and

''(ii) any attachment relating to such request or response.

''(B) ELECTRONIC TRANSMISSION.—

''(i) EXCLUSIONS.—For purposes of this paragraph, a facsimile, a proprietary payer

portal that does not meet standards specified by the Secretary, or an electronic form shall not be treated as an electronic transmission described in subparagraph (A).

''(ii) STANDARDS.—An electronic transmission described in subparagraph (A) shall comply with—

''(I) applicable technical standards adopted by the Secretary pursuant to section 1173; and

''(II) other requirements to promote the standardization and streamlining of electronic transactions under this part specified by the Secretary.

''(iii) DEADLINE FOR SPECIFICATION OF ADDITIONAL REQUIREMENTS.—Not later than July 1, 2023, the Secretary shall finalize requirements described in clause (ii)(II).

''(C) REAL-TIME DECISIONS.—

''(i) IN GENERAL.—Subject to clause (iv), the program described in subparagraph (A) shall provide for real-time decisions (as defined by the Secretary in accordance with clause (v)) by a Medicare Advantage plan with respect to prior authorization requests for applicable items and services identified by the Secretary pursuant to clause (ii) if such requests are submitted with all medical or other documentation required by such plan.

''(ii) IDENTIFICATION OF ITEMS AND SERVICES.—

''(I) IN GENERAL.—For purposes of clause (i), the Secretary shall identify, not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for the third plan year beginning after the date of the enactment of this subsection is required to be announced, applicable items and services for which prior authorization requests are routinely approved.

''(II) UPDATES.—The Secretary shall consider updating the applicable items and services identified under subclause (I) based on the information described in paragraph (3)(A)(i) (if available and determined practicable to utilize by the Secretary) and any other information determined appropriate by the Secretary not less frequently than biennially. The Secretary shall announce any such update that is to apply with respect to a plan year not later than the date on which the initial announcement described in section 1853(b)(1)(B)(i) for such plan year is required to be announced.

''(iii) REQUEST FOR INFORMATION.—The Secretary shall issue a request for information for purposes of initially identifying applicable items and services under clause (ii)(I).

''(iv) EXCEPTION FOR EXTENUATING CIRCUMSTANCES.—In the case of a prior authorization request submitted to a Medicare Advantage plan for an individual enrolled in such plan during a plan year with respect to an item or service identified by the Secretary pursuant to clause (ii) for such plan year, such plan may, in lieu of providing a real-time decision with respect to such request in accordance with clause (i), delay such decision under extenuating circumstances (as specified by the Secretary), provided that such decision is provided no later than 72 hours after receipt of such request (or, in the case that the provider of services or supplier submitting such request has indicated that such delay may seriously jeopardize such individual's life, health, or ability to regain maximum function, no later than 24 hours after receipt of such request).

''(v) DEFINITION OF REAL-TIME DECISION.—In establishing the definition of a real-time decision for purposes of clause (i), the Secretary shall take into account current medical practice, technology, health care industry standards, and other relevant information relating to how quickly a Medicare Advantage plan may provide responses with respect to prior authorization requests.

''(vi) IMPLEMENTATION.—The Secretary shall use notice and comment rulemaking for each of the following:

''(I) Establishing the definition of a 'real-time decision' for purposes of clause (i).

''(II) Updating such definition.

''(III) Initially identifying applicable items or services pursuant to clause (ii)(I).

''(IV) Updating applicable items and services so identified as described in clause (ii)(II).

''(3) TRANSPARENCY REQUIREMENTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the transparency requirements specified in this paragraph are, with respect to a Medicare Advantage plan, the following:

''(i) The plan, annually and in a manner specified by the Secretary, shall submit to the Secretary the following information:

''(I) A list of all applicable items and services that were subject to a prior authorization requirement under the plan during the previous plan year.

''(II) The percentage and number of specified requests (as defined in subparagraph (F)) approved during the previous plan year by the plan in an initial determination and the percentage and number of specified requests denied during such plan year by such plan in an initial determination (both in the aggregate and categorized by each item and service).

''(III) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year, and the percentage and number of such requests that were subject to an exception under paragraph (2)(C)(iv) (categorized by each item and service).

''(IV) The percentage and number of specified requests submitted during the previous plan year that were made with respect to an item or service identified by the Secretary pursuant to paragraph (2)(C)(ii) for such plan year that were approved (categorized by each item and service).

''(V) The percentage and number of specified requests that were denied during the previous plan year by the plan in an initial determination and that were subsequently appealed.

''(VI) The number of appeals of specified requests resolved during the preceding plan year, and the percentage and number of such resolved appeals that resulted in approval of the furnishing of the item or service that was the subject of such request, categorized by each applicable item and service and categorized by each level of appeal (including judicial review).

''(VII) The percentage and number of specified requests that were denied, and the percentage and number of specified requests that were approved, by the plan during the previous plan year through the utilization of decision support technology, artificial intelligence technology, machine-learning technology, clinical decision-making technology, or any other technology specified by the Secretary.

''(VIII) The average and the median amount of time (in hours) that elapsed during the previous plan year between the submission of a specified request to the plan and a determination by the plan with respect to such request for each such item and service, excluding any such requests that were not submitted with the medical or other documentation required to be submitted by the plan.

''(IX) The percentage and number of specified requests that were excluded from the calculation described in subclause (VIII) based on the plan's determination that such requests were not submitted with the medical or other documentation required to be submitted by the plan.

''(X) Information on each occurrence during the previous plan year in which, during a surgical or medical procedure involving the furnishing of an applicable item or service with respect to which such plan had approved a prior authorization request, the provider of services or supplier furnishing such item or service determined that a different or additional item or service was medically necessary, including a specification of whether such plan subsequently approved the furnishing of such different or additional item or service.

''(XI) A disclosure and description of any technology described in subclause (VII) that the plan utilized during the previous plan year in making determinations with respect to specified requests.

''(XII) The number of grievances (as described in subsection (f)) received by such plan during the previous plan year that were related to a prior authorization requirement.

''(XIII) Such other information as the Secretary determines appropriate.

''(ii) The plan shall provide—

''(I) to each provider or supplier who seeks to enter into a contract with such plan to furnish applicable items and services under such plan, the list described in clause (i)(I) and any policies or procedures used by the plan for making determinations with respect to prior authorization requests;

''(II) to each such provider and supplier that enters into such a contract, access to the criteria used by the plan for making such determinations and an itemization of the medical or other documentation required to be submitted by a provider or supplier with respect to such a request; and

''(III) to an enrollee of the plan, upon request, access to the criteria used by the plan for making determinations with respect to prior authorization requests for an item or service.

''(B) OPTION FOR PLAN TO PROVIDE CERTAIN ADDITIONAL INFORMATION.—As part of the information described in subparagraph (A)(i) provided to the Secretary during a plan year, a Medicare Advantage plan may elect to include information regarding the percentage and number of specified requests made with respect to an individual and an item or service that were denied by the plan during the preceding plan year in an initial determination based on such requests failing to demonstrate that such individuals met the clinical criteria established by such plan to receive such items or services.

''(C) REGULATIONS.—The Secretary shall, through notice and comment rulemaking, establish requirements for Medicare Advantage plans regarding the provision of—

''(i) access to criteria described in subparagraph (A)(ii)(II) to providers of services and suppliers in accordance with such subparagraph; and

''(ii) access to such criteria to enrollees in accordance with subparagraph (A)(ii)(III).

''(D) PUBLICATION OF INFORMATION.—The Secretary shall publish information described in subparagraph (A)(i) and subparagraph (B) on a public website of the Centers for Medicare & Medicaid Services. Such information shall be so published on an individual plan level and may in addition be aggregated in such manner as determined appropriate by the Secretary.

''(E) MEDPAC REPORT.—Not later than 3 years after the date information is first submitted under subparagraph (A)(i), the Medicare Payment Advisory Commission shall submit to Congress a report on such information that includes a descriptive analysis of the use of prior authorization. As appropriate, the Commission should report on statistics including the frequency of appeals

and overturned decisions. The Commission shall provide recommendations, as appropriate, on any improvement that should be made to the electronic prior authorization programs of Medicare Advantage plans.

''(F) SPECIFIED REQUEST DEFINED.—For purposes of this paragraph, the term 'specified request' means a prior authorization request made with respect to an applicable item or service.

''(4) ENROLLEE PROTECTION STANDARDS.—For purposes of paragraph (1)(A)(ii), the Secretary shall, through notice and comment rulemaking, specify the following enrollee protection standards with respect to the use of prior authorization by Medicare Advantage plans for applicable items and services:

''(A) Adoption of transparent prior authorization programs developed in consultation with enrollees and with providers and suppliers with contracts in effect with such plans for furnishing such items and services under such plans;

''(B) Allowing for the waiver or modification of prior authorization requirements based on the performance of such providers and suppliers in demonstrating compliance with such requirements, such as adherence to evidence-based medical guidelines and other quality criteria; and

''(C) Conducting annual reviews of such items and services for which prior authorization requirements are imposed under such plans through a process that takes into account input from enrollees and from providers and suppliers with such contracts in effect and is based on consideration of prior authorization data from previous plan years and analyses of current coverage criteria.

''(5) APPLICABLE ITEM OR SERVICE.—For purposes of this subsection, the term 'applicable item or service' means, with respect to a Medicare Advantage plan, any item or service for which benefits are available under such plan, other than a covered part D drug.

''(6) REPORTS TO CONGRESS.—

''(A) GAO.—Not later than the end of the fourth plan year beginning on or after the date of the enactment of this subsection, the Comptroller General of the United States shall submit to Congress a report containing an evaluation of the implementation of the requirements of this subsection and an analysis of issues in implementing such requirements faced by Medicare Advantage plans.

''(B) HHS.—Not later than the end of the fifth plan year beginning after the date of the enactment of this subsection, and biennially thereafter through the date that is 10 years after such date of enactment, the Secretary shall submit to Congress a report containing a description of the information submitted under paragraph (3)(A)(i) during—

''(i) in the case of the first such report, the fourth plan year beginning after the date of the enactment of this subsection; and

''(ii) in the case of a subsequent report, the 2 plan years preceding the year of the submission of such report.''.

(b) ENSURING TIMELY RESPONSES FOR ALL PRIOR AUTHORIZATION REQUESTS SUBMITTED UNDER PART C.—Section 1852(g) of the Social Security Act (42 U.S.C. 1395w–22(g)) is amended—

(1) in paragraph (1)(A), by inserting ''and in accordance with paragraph (6)'' after ''paragraph (3)'';

(2) in paragraph (3)(B)(iii), by inserting ''(or, subject to subsection (o), with respect to prior authorization requests submitted on or after the first day of the third plan year beginning after the date of the enactment of the Improving Seniors' Timely Access to Care Act of 2022, not later than 24 hours)'' after ''72 hours''.

(3) by adding at the end the following new paragraph:

''(6) TIMEFRAME FOR RESPONSE TO PRIOR AUTHORIZATION REQUESTS.—Subject to paragraph (3) and subsection (o), in the case of an organization determination made with respect to a prior authorization request for an item or service to be furnished to an individual submitted on or after the first day of the third plan year beginning after the date of the enactment of this paragraph, the organization shall notify the enrollee (and the physician involved, as appropriate) of such determination no later than 7 days (or such shorter timeframe as the Secretary may specify through notice and comment rulemaking, taking into account enrollee and stakeholder feedback) after receipt of such request.''.

SEC. 3. FUNDING.

The Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) (in such proportion as determined appropriate by the Secretary) to the Centers for Medicare & Medicaid Services Program Management Account, of $25,000,000 for fiscal year 2022, to remain available until expended, for purposes of carrying out the amendments made by this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Washington (Ms. DELBENE) and the gentleman from Pennsylvania (Mr. KELLY) each will control 20 minutes.

The Chair recognizes the gentlewoman from Washington.

GENERAL LEAVE

Ms. DELBENE. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Washington?

There was no objection.

Ms. DELBENE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, more than 28 million seniors get healthcare through Medicare Advantage, including 600,000 in Washington State.

For these seniors and the physicians that care for them, we must deliver a quality product that allows providers to keep our seniors as healthy as possible while reducing wait times, paperwork, and hassle.

Unfortunately, the cumbersome and antiquated prior authorization process that many Medicare Advantage plans utilize often gets in the way. This involves multiple phone calls and faxing documents to insurance companies. It is 2022, and even Congress has moved beyond faxing.

The HHS Inspector General recently reported that prior authorization is responsible for delaying and even denying medically necessary care. That mirrors reports that we have heard from providers for years now.

In one case, the inspector general found that, due to prior authorization, a 76-year-old Medicare beneficiary with post-polio syndrome was denied a request for a walker.

In another case, a Washington State resident and professional fisherman had to miss this past summer's fishing season in Alaska because his hip surgery was delayed for months.

According to the American Medical Association, one out of every four physicians report that prior authorization has led to a patient being hospitalized. Prior authorization is also a burden on providers, who spend 13 hours a week completing prior authorization paperwork, often for procedures that are approved over 95 percent of the time. That is time they could be spending with patients.

Today, the House of Representatives will take a major step forward in resolving this problem. The Improving Seniors' Timely Access to Care Act will make commonsense changes to prior authorization to ensure our seniors are getting the care they need when they need it.

First, the bill would require all plans to use an electronic prior authorization system. That means no more phone calls, no more faxes, and no more wondering what information is needed to submit to insurance plans when requesting prior authorization.

Second, we establish a process for real-time decisionmaking. It doesn't make sense that services in line with standard clinical practice guidelines or services that are approved more than 95 percent of the time are subject to prior authorization.

We also know that delayed approvals can result in patients falling through the cracks and missing out on care. Real-time decisions will help stop that.

Finally, this bill requires reporting on the number of prior authorization requests, the rates of approvals and denials, and the rates of successful appeals to increase transparency.

Collectively, this bill will help providers spend more time with patients and less time with paperwork.

Today's vote and the teamwork that brought this legislation to this moment is a bipartisan success story that shows that Congress can come together and put the needs of the American people before the gridlock that we all know too well.

Mr. Speaker, I thank Representative MIKE KELLY, our Republican lead, for his tireless work on this for years, also our co-leads, Dr. AMI BERA and LARRY BUCSHON, as well as Senator ROGER MARSHALL, who worked with us when he was in the House in the 116th Congress and has continued this effort in the Senate.

I thank the over 300 of my colleagues on both sides of the aisle who have cosponsored this bill. The support for this legislation has been overwhelming and it has been endorsed by over 500 healthcare organizations.

I particularly thank the Regulatory Relief Coalition and the American Medical Association that helped develop a quality bill and build support for it.

Mr. Speaker, I include in the RECORD a list of endorsements and the letters

of support from the Regulatory Relief Coalition and the American Medical Association.

THE IMPROVING SENIORS' TIMELY ACCESS TO CARE ACT OF 2021 (S. 3018/H.R. 3173)

List of 500 Supporting Organizations (as of 7/6/2022)

NATIONAL SUPPORTERS

2020 Mom, ACCSES, Academy of Consultation-Liaison Psychiatry, Accuray, Inc., AdvaMed, Aimed Alliance, ALK Positive, Inc., Alliance for Aging Research, Alliance for Headache Disorders Advocacy, Alliance for Patient Access, Alliance of Specialty Medicine, ALS Association, Alzheimer's Association and Alzheimer's Impact movement, America's Physician Groups, American Academy of Allergy, Asthma & Immunology, American Academy of Child and Adolescent Psychiatry, American Academy of Dermatology Association, American Academy of Emergency Medicine, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Otolaryngic Allergy, American Academy of Otolaryngology—Head and Neck Surgery, American Academy of PAs.

American Academy of Physical Medicine and Rehabilitation, American Academy of Sleep Medicine, American Association for Hand Surgery, American Association for Homecare, American Association for Marriage and Family Therapy, American Association for Pediatric Ophthalmology and Strabismus, American Association for Physician Leadership, American Association for Psychoanalysis in Clinical Social Work, American Association of Clinical Endocrinology, American Association of Clinical Urologists, American Association of Neurological Surgeons, American Association of Neuromuscular & Electrodiagnostic Medicine, American Association of Nurse Anesthetists, American Association of Orthopaedic Surgeons, American Association on Health and Disability, American Clinical Laboratory Association, American Clinical Neurophysiology Society, American College of Allergy, Asthma and Immunology, American College of Cardiology, American College of Emergency Physicians, American College of Gastroenterology, American College of Medical Genetics and Genomics, American College of Mohs Surgery, American College of Obstetricians and Gynecologists.

American College of Osteopathic Internists, American College of Osteopathic Surgeons, American College of Physicians, American College of Radiation Oncology, American College of Radiology, American College of Rheumatology, American College of Surgeons, American Counseling Association, American Epilepsy Society, American Foundation for Suicide Prevention, American Gastroenterological Association, American Geriatrics Society, American Glaucoma Society, American Group Psychotherapy Association, American Health Information Management Association, American Hospital Association, American Institute of Ultrasound in Medicine, American Medical Association, American Medical Rehabilitation Providers Association, American Medical Women's Association, American Mental Health Counselors Association, American Nurses Association, American Occupational Therapy Association, American Optometric Association, American Osteopathic Association, American Osteopathic College of Ophthalmology, American Physical Therapy Association, American Psychiatric Association, American Psychiatric Nurses Association, American Psychoanalytic Association, American Psychological Association, American Society for Clinical Pathology, American Society for Gastrointestinal Endoscopy.

American Society for Laser Medicine and Surgery, American Society for Radiation Oncology, American Society of Anesthesiologists, American Society of Breast Surgeons, American Society of Cataract and Refractive Surgery, American Society of Dermatopathology, American Society of Echocadiography, American Society of Hematology, American Society of Neuroradiology, American Society of Nuclear Cardiology, The American Society of Pain and Neuroscience, American Society of Plastic Surgeons, American Society of Retina Specialists, American Society of Transplant Surgeons, American Society of Transplant Surgeons (ASTS), American Society of Echocardiography, American Therapeutic Recreation Association, American Urogynecologic Society, American Urological Association, American Vein & Lymphatic Society, American Venous Forum, America's Essential Hospitals, Anxiety and Depression Association of America, Arthritis Foundation, Association for Ambulatory Behavioral Healthcare, Association for Clinical Oncology, Association of Academic Physiatrists, Association of Black Cardiologists, Association of Community Cancer Centers, Association of Freestanding Radiation Oncology Centers, Association of Mature American Citizens, Association of Rehabilitation Nurses, Association of University Professors of Ophthalmology.

Association of Women in Rheumatology, Better Medicare Alliance, Beyond Type 1, Boston Scientific, Brain Injury Association of America, Bridge the Gap—SYNGAP Education and Research Foundation, Cancer Support Community, CancerCare, Case Management Society of America, CHAMP—Coalition for Headache and Migraine Patients, Change Healthcare, Child Neurology Society, Children and Adults with Attention-Deficit/Hyperactivity Disorder, Chris CJ Johnson Foundation Inc., Christopher & Dana Reeve Foundation, Chronic Care Policy Alliance, Clinical Social Work Association, Coalition of Long-Term Acute-Care Hospitals, Cohere Health, College of Psychiatric and Neurologic Pharmacists, Community Liver Alliance, Community Oncology Alliance, Congress of Clinical Rheumatology, Congress of Neurological Surgeons, Consortium of Multiple Sclerosis Centers, Continuum Therapy Partners, Cooley's Anemia Foundation, Cornea Society, Corporation for Supportive Housing (CSH), Depression and Bipolar Support Alliance, Diabetes Leadership Council, Diabetes Patient Advocacy Coalition.

Driven To Cure, Eating Disorders Coalition for Research, Policy & Action, Endocrine Society, Epic Systems, Epilepsy Foundation, Eye Bank Association of America, Falling Forward Foundation, Federation of American Hospitals, Ferrell Foundation, Free2Care, Global Alliance for Behavioral Health and Social Justice, Global Healthy Living Foundation, Global Liver Institute, GO2 Foundation for Lung Cancer, The Headache and Migraine Policy Forum, Healthcare Information and Management Systems Society, HealthPRO-Heritage, Hematology/Oncology Pharmacy Association, Hyperemesis Education and Research Foundation, International Essential Tremor Foundation, International Foundation for Autoimmune & Autoinflammatory Arthritis, International OCD Foundation, Johnson & Johnson, Judy Nicholson Kidney Cancer Foundation, KCCure (Kidney Cancer Research Alliance), The Kennedy Forum, Kidney Cancer Association, KidneyCAN, Lakeshore Foundation, LeadingAge, The Leukemia & Lymphoma Society, Lupus and Allied Diseases Association, Inc.

Maternal Mental Health Leadership Alliance, Medical Device Manufacturers Association, Medical Group Management Association, Medical Oncology Association of Southern California, Mental Health America, The Michael J. Fox Foundation for Parkinson's Research, Multiple Sclerosis Association of America, NAADAC, the Association for Addiction Professionals, National Alliance of Safety-Net Hospitals, National Alliance on Mental Illness, National Association for Behavioral Healthcare, National Association for Children's Behavioral Health, National Association for Home Care & Hospice, National Association for the Advancement of Orthotics and Prosthetics, National Association for the Support of Long Term Care, National Association of ACOs, National Association of Epilepsy Centers, National Association of Rehab Providers & Agencies, National Association of Social Workers, National Association of Spine Specialists, National Association of State Head Injury Administrators, National Association of State Mental Health Program Directors, National Community Pharmacists Association, National Comprehensive Cancer Network, National Council for Mental Wellbeing, National Disability Rights Network, National Eating Disorders Association, National Federation of Families, National Hispanic Medical Association.

National Kidney Foundation, National League for Nursing, National Multiple Sclerosis Society, National Osteoporosis Foundation, National Patient Advocate Foundation, National Register of Health Service Psychologists, NHMH—No Health without Mental Health, Nomi Health, North American Neuro-Ophthalmology Society, OCHIN, Outpatient Ophthalmic Surgery Society, Pacific Spine & Pain Society, Partnership for Quality Home Healthcare, Patients Rising, Patients Rising Now, Physician Hospitals of America, Physicians Advocacy Institute, Postpartum Support International, Premier, Private Practice Section (PPS) of the American Physical Therapy Association (APTA), Prostate Network, Pulmonary Fibrosis Foundation, R.M.C. Inc., REDC Consortium, Regulatory Relief Coalition, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA), Remote Cardiac Services Providers Group, Renal Physicians Association, RetireSafe, SMART Recovery, Society for Cardiovascular Angiography and Interventions, Society for Cardiovascular Magnetic Resonance, Society for Vascular Surgery.

Society of Cardiovascular Computed Tomography, Society of Gynecologic Oncology, Society of Hospital Medicine, Society of Interventional Radiology, The Society of Thoracic Surgeons, Spina Bifida Association, Spine Intervention Society, Susan G. Komen, Sterling Vision, Tourette Association of America, Treatment Communities of America, Triage Cancer, VHL Alliance, ZERO—The End of Prostate Cancer.

STATE SUPPORTERS

Medical Association of the State of Alabama, Alabama Academy of Ophthalmology, Alabama Association of Health Information Management, Alabama Cancer Congress, Alabama Chapter, American College of Surgeons, Alabama Society for the Rheumatic Diseases, Alaska Chapter, American College of Surgeons, The Arizona Clinical Oncology Society, Arizona Chapter, American College of Surgeons, Arizona Health Information Management Association, Arizona Neurosurgical Society, Arkansas Chapter, American College of Surgeons, Arkansas Medical Society, Arkansas Ophthalmological Society, Arkansas Orthopaedic Society, Arkansas Rheumatology Association, Association of Northern California Oncologists, Brooklyn-Long Island Chapter, American College of Surgeons, California Medical Association, California Academy of Eye Physicians and Surgeons, California Association of

Neurological Surgeons, Medical Oncology Association of Southern California, Inc., Centura Health.

Colorado Chapter, American College of Surgeons, Colorado Medical Society, Colorado Society of Eye Physicians & Surgeons, Community Care Network of Kansas, Connecticut Chapter, American College of Surgeons, Connecticut Oncology Association, Connecticut State Medical Society, Medical Society of Delaware, Delaware Chapter, American College of Surgeons, Delaware Society for Clinical Oncology, Medical Society of the District of Columbia, Denali Oncology Group, DHR Health, Eastern Long Island Chapter, American College of Surgeons, Empire State Hematology and Oncology Society, Florida Medical Association, Florida Academy of Family Physicians, Florida Chapter, American College of Surgeons, Florida Health Information Management Association, Florida Neurosurgical Society, Florida Society of Clinical Oncology, The Florida Society of Neurology, Florida Society of Ophthalmology, Medical Association of Georgia, Georgia Neurological Society, Georgia Society of Clinical Oncology, Georgia Society of Ophthalmology.

Georgia Society of the American College of Surgeons, Guam Chapter, American College of Surgeons, Hawaii Medical Association, Hawaii Chapter, American College of Surgeons, Hawaii Society of Clinical Oncology, Idaho Medical Association, Idaho Chapter, American College of Surgeons, Illinois State Medical Society, Illinois Academy of Family Physicians, Illinois Chapter, American College of Surgeons, Illinois Medical Oncology Society, Illinois State Neurosurgical Society, Indiana State Medical Association, Indiana Academy of Ophthalmology, Indiana Chapter, American College of Surgeons, Indiana Neurological Society, Indiana Oncology Society, Iowa Chapter, American College of Surgeons, Iowa Medical Society, Iowa Oncology Society, Jacksonville Chapter, American College of Surgeons, Kansas Chapter, American College of Surgeons, Kansas Health Information Management Association, Kansas Hospital Association, Kansas Medical Society, Kansas Radiological Society, Kansas Society of Clinical Oncology.

Kentucky Medical Association, Kentucky Academy of Eye Physicians & Surgeons, Kentucky Chapter, American College of Surgeons, Kentucky Society of Clinical Oncology, Keystone Chapter, American College of Surgeons, Lake Plains Medical PLLC, Life Sciences Pennsylvania, Louisiana State Medical Society, Louisiana Academy of Family Physicians, Louisiana Chapter, American College of Surgeons, Louisiana Oncology Society, Maine Medical Association, Maine Chapter, American College of Surgeons, Maine Society of Eye Physicians and Surgeons, Maryland Chapter, American College of Surgeons, Maryland Society of Eye Physicians and Surgeons, Maryland/DC Society of Clinical Oncology, Massachusetts Chapter, American College of Surgeons, Massachusetts Health Information Management Association (MaHIMA), Massachusetts Medical Society, Massachusetts Society of Clinical Oncologists, Massachusetts Society of Eye Physicians & Surgeons, MedChi, The Maryland State Medical Society, Metropolitan Chicago Chapter, American College of Surgeons, Metropolitan Philadelphia Chapter, American College of Surgeons.

Metropolitan Washington DC Chapter, American College of Surgeons, Michigan Chapter, American College of Surgeons, Michigan Society of Hematology and Oncology, Michigan State Medical Society, Midwest Association for Medical Equipment Services & Supplies, MidWest Rheumatology Association, Minnesota Medical Association, Minnesota Academy of Ophthalmology, Minnesota Health Information Management Association, Minnesota Society of Clinical Oncology, Minnesota Surgical Society—a Chapter of the ACS, American College of Surgeons, Mississippi State Medical Association, Mississippi Chapter, American College of Surgeons, Mississippi Oncology Society, Missouri State Medical Association, Missouri Academy of Family Physicians, Missouri Chapter, American College of Surgeons, Missouri Oncology Society, Montana Medical Association, Montana Academy of Family Physicians, Montana and Wyoming Chapter, American College of Surgeons, Montana State Oncology Society, MSARS, Nebraska Medical Association, Nebraska Academy of Eye Physicians and Surgeons, Nebraska Chapter, American College of Surgeons, Nebraska Neurological Society.

Nebraska Oncology Society, Neurosurgical Society of the Virginias, Nevada State Medical Association, Nevada Chapter, American College of Surgeons, Nevada Health Information Management Association, Nevada Oncology Society, New Hampshire Medical Society, New Hampshire Chapter, American College of Surgeons, Medical Society of New Jersey, New Jersey Academy of Ophthalmology, New Jersey Chapter, American College of Surgeons, New Jersey Health Information Management Association, Medical Oncology Society of New Jersey, New Mexico Chapter, American College of Surgeons, New Mexico Medical Society, New Mexico Society of Clinical Oncology, Medical Society of the State of New York, New York Chapter, American College of Surgeons, New York State Academy of Family Physicians, New York State Neurosurgical Society, New York State Ophthalmological Society, North Carolina Chapter, American College of Surgeons, North Carolina Medical Society, North Carolina Oncology Association, North Carolina Society of Eye Physicians and Surgeons, North Dakota Medical Association, North Dakota Chapter, American College of Surgeons.

North Texas Chapter, American College of Surgeons, Northern California Chapter, American College of Surgeons, Northern New England Clinical Oncology Society, Northwestern Pennsylvania Chapter, American College of Surgeons, Ohio State Medical Association, Ohio Academy of Family Physicians, Ohio Association of Rheumatology, Ohio Chapter, American College of Surgeons, Ohio Health Information Management Association, Ohio Hematology Oncology Society Oklahoma State Medical Association, Oklahoma Chapter, American College of Surgeons, Oklahoma Society of Clinical Oncology Oregon Medical Association, Oregon Academy of Family Physicians, Oregon Academy of Ophthalmology, Oregon Chapter, American College of Surgeons, Oregon Society of Medical Oncology, Pennsylvania Medical Society, Pennsylvania Academy of Ophthalmology, Pennsylvania Chapter of the American College of Cardiology, Pennsylvania Medical Society, Pennsylvania Neurosurgical Society, Pennsylvania Rheumatology Society, Pennsylvania Society of Oncology & Hematology, The Hospital and Healthsystem Association of Pennsylvania, PHIMA.

Prodigy Rehabilitation Group, Inc., PT Northwest, Puerto Rico Chapter, American College of Surgeons, Puerto Rico Hematology and Medical Oncology Association, Rhode Island Chapter, American College of Surgeons, Rhode Island Health Information Management Association, Rhode Island Medical Society, Rhode Island Neurological Society, Rocky Mountain Oncology Society, San Diego Chapter, American College of Surgeons, Society of Utah Medical Oncologists, South Carolina Chapter, American College of Surgeons, South Carolina Oncology Society, South Dakota Academy of Ophthalmology, South Dakota Chapter, American College of Surgeons, South Florida Chapter, American College of Surgeons, South Texas Chapter, American College of Surgeons, Southern California Chapter, American College of Surgeons, Southwest Missouri Chapter, American College of Surgeons, Southwestern Pennsylvania Chapter, American College of Surgeons, Tennessee Medical Association, Tennessee Chapter, American College of Surgeons, Tennessee Oncology Practice Society, Texas Medical Association, Texas Academy of Family Physicians.

Texas Hospital Association, Texas Ophthalmological Association, Texas Society of Clinical Oncology, Transitional Care Management, Utah Medical Association, Utah Chapter, American College of Surgeons, Utah Ophthalmology Society, Vermont Chapter, American College of Surgeons, Vermont Medical Society, Medical Society of Virginia, Virginia Association of Hematologist & Oncologist, Virginia Chapter, American College of Surgeons, Virginia Society of Eye Physicians and Surgeons, Washington D.C. Metropolitan Ophthalmological Society, Washington State Medical Association, Washington Academy of Eye Physicians & Surgeons, Washington Academy of Family Physicians, Washington Chapter, American College of Surgeons, Washington State Association of Neurological Surgeons.

Washington Rheumatology Alliance, Washington State Medical Oncology Society, West Virginia Chapter, American College of Surgeons, West Virginia Oncology Society, West Virginia Orthopaedic Society, Western New York Chapter, American College of Surgeons, Wisconsin Medical Society, Wisconsin Academy of Ophthalmology, Wisconsin Association of Hematology & Oncology, Wisconsin Health Information Management Association, Wisconsin Hospital Association, Wisconsin Neurological Society, Wisconsin Rheumatology Association, Wisconsin Surgical Society—a Chapter of the ACS, The Woman's Group, Wyoming Medical Society, Wyoming State Oncology Society.

REGULATORY RELIEF COALITION,
September 12, 2022.

Hon. NANCY PELOSI,
Speaker, House of Representatives,
Washington, DC.
Hon. KEVIN MCCARTHY,
Republican Leader, House of Representatives,
Washington, DC.

DEAR SPEAKER PELOSI AND LEADER MCCARTHY: Members of the Regulatory Relief Coalition (RRC)—a group of national physician specialty organizations advocating for reduced regulatory burdens that interfere with patient care—thank you for scheduling a House floor vote on the Improving Seniors' Timely Access to Care Act on September 14, 2022.

This bipartisan bill is supported by more than 310 House co-sponsors and over 500 endorsing organizations representing patients, health care providers, medical technology and biopharmaceutical industry, health plans and others. The RRC's goal is to ensure that bureaucratic hurdles do not stand in the way of physicians providing medically necessary patient care.

The Improving Seniors' Timely Access to Care Act would improve prior authorization in the Medicare Advantage (MA) program by:

Establishing an electronic prior authorization (ePA) program;

Standardizing and streamlining the prior authorization process for routinely approved services, including establishing a list of services eligible for real-time prior authorization decisions;

Ensuring prior authorization requests are reviewed by qualified medical personnel; and

Increasing transparency on MA prior authorization requirements and their use.

The RRC, which served as a lead stakeholder and key negotiator of the legislation, especially appreciates the tireless work of Reps. Suzan DelBene (D–WA), Mike Kelly (R–PA), Ami Bera, MD (D–CA) and Larry Bucshon, MD (R–IN) for their efforts leading up to this vote.

We urge the House to vote in favor of this critical legislation.

If you have any questions, please contact Peggy Tighe.

Thank you.

Sincerely,

The Regulatory Relief Coalition, American Academy of Family Physicians, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Association of Neurological Surgeons, American College of Cardiology, American College of Rheumatology, American College of Surgeons, American Gastroenterological Association, American Osteopathic Association, Association For Clinical Oncology, Congress of Neurological Surgeons, Medical Group Management Association, National Association of Spine Specialists, Society for Cardiovascular Angiography & Interventions.

AMERICAN MEDICAL ASSOCIATION,
September 13, 2022.

Hon. NANCY PELOSI,
Speaker, House of Representatives, Washington, DC.
Hon. KEVIN MCCARTHY,
Minority Leader, House of Representatives, Washington, DC.

DEAR SPEAKER PELOSI AND RANKING MEMBER MCCARTHY: On behalf of the physician and medical student members of the American Medical Association (AMA), I write in strong support of H.R. 3173, the ''Improving Seniors' Timely Access to Care Act of 2022.'' This legislation, as originally introduced, garnered more than 300 bipartisan House cosponsors and the support of approximately 500 physician, hospital, patient, and insurer organizations. We greatly appreciate the House of Representatives scheduling a vote on this bipartisan legislation, which was favorably reported out of the Ways and Means Committee in July, and strongly urge swift passage to help streamline, simplify, and standardize prior authorization processes within Medicare Advantage (MA) plans.

Prior authorization, which is the practice by insurance companies of reviewing and potentially denying medical services and pharmaceuticals prior to treatment, remains a principal frustration for patients and physicians. This utilization management policy is overused, costly, opaque, burdensome to physicians, and harmful to patients due to delays in care.

AMA data compiled from annual surveys of more than 1,000 practicing physicians continue to illustrate the negative impact of prior authorization policies. In fact, 34 percent of physicians who participated in a 2021 AMA survey reported that prior authorization led to a serious adverse event, such as hospitalization, disability, permanent bodily damage, or even death, for a patient in their care. The 2021 survey also highlights that 93 percent of physicians reported care delays associated with prior authorization, while 82 percent of respondents cited that these requirements can at least sometimes lead to patients abandoning treatments.

In addition, research from the federal government demonstrates that prior authorization leads to delays in patient care and inappropriate denials of medically necessary services. A 2018 report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) concluded that, between 2014 and 2016, MA plans overturned 75 percent oftheir own prior authorization and payment denials when appealed by providers and beneficiaries. An April 2022 HHS OIG report also found that 13 percent of prior authorization requests denied by MA plans met Medicare coverage rules, and 18 percent of payment request denials met Medicare and MA billing rules.

We commend the House of Representatives for working in a bipartisan fashion to develop an amended version of the Improving Seniors' Timely Access to Care Act. The modified legislation retains the crux of the original bill, the ''Improving Seniors' Timely Access to Care Act of 2021,'' including mandating that MA plans implement electronic prior authorization programs that adhere to new standards adopted by the federal government. This will help ensure that physicians are no longer forced to resort to faxes and e-forms, or even disparate, proprietary portals that fail to comply with these newly developed standards, when seeking to complete prior authorization requests. In addition, the provisions requiring robust data reporting, such as the number and percentage of prior authorization requests approved, denied, or approved upon appeal, will bring much needed transparency to ensure MA prior authorization programs are not inappropriately denying medically necessary care to patients and overburdening physicians with unnecessary requirements.

Most importantly, the additional sections of the legislation mandating MA plans to issue faster prior authorization decisions are crucial policy improvements that will ensure more timely access to care and, as a result, improve patient health care outcomes and better stewardship of scarce Medicare resources. The AMA supports the requirements for health plans to provide real-time prior authorization decisions for routinely approved services, as defined in implementing regulations. We also appreciate that the bill directs MA plans unable to meet the real-time processing requirement in the event of ''extenuating circumstances'' to issue final prior authorization decisions within a 72-hour and 24-hour timeline for regular and emergent services, respectively. Notably, the legislation requires MA plans to report the number of prior authorizations subject to this exception, providing the transparency needed to deter abuse of this provision.

In addition, we sincerely appreciate the inclusion of provisions pertaining to more timely prior authorization decisions for all other services within Medicare Part C. Requiring MA plans to issue final decisions within 24 hours for emergent services and no later than seven days after receipt of regular prior authorization requests is a vast improvement over current MA program practices. The expedited timelines for MA plans to issue final prior authorization decisions, both for routinely approved care and all other services, will undoubtedly lessen the burden on physicians, and, most significantly, ensure timely patient care and improved health outcomes.

The AMA is proud to support the Improving Seniors' Timely Access to Care Act. We commend the House of Representatives for voting on this legislation and stand ready to work to ensure bipartisan passage by the Senate.

Sincerely,

JAMES L. MADARA, MD.

Ms. DELBENE. Mr. Speaker, I also thank the staff from the personal offices and from the committee and leadership offices that have spent countless hours researching this issue and working with stakeholders to develop this legislation.

In particular, I thank my former legislative director, Kyle Hill, who was truly integral in developing and advancing this legislation.

Mr. Speaker, I urge all of my colleagues to support this legislation, and I reserve the balance of my time.

Mr. KELLY of Pennsylvania. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I thank Representative DELBENE for being with me today.

We are really proud of this bill because it has taken a lot of time to get there, and it has taken so many people on both sides of the aisle looking at it and saying this is something that just makes sense.

The purpose of the Improving Seniors' Timely Access to Care Act is very simple: it is to protect our seniors. They deserve fast, high-quality care when they see their doctor, not bureaucratic paperwork and delays. Unfortunately, our current prior authorization system often produces just that.

My office has heard countless stories of Pennsylvanians being affected by having their care delayed due to prior authorizations. One ophthalmology practice reported that they had problems getting both of a patients' eyes authorized for a basic operation because the system rejected the second eye as a duplicate.

At the University of Pittsburgh's Department of Neurosurgery, doctors can perform an advanced surgery with a Gamma Knife to control brain tumors. In many cases, these operations give patients life and more time. The problem is that it takes prior authorization, and care is delayed for way, way too long costing patients' valuable time.

As a result, patients lose confidence in the medical system, and they also begin to lose hope. That is why we are here today, to move the prior authorization process into the 21st century and give doctors and health insurance plans the tools they need to make these decisions more quickly.

The current system allows insurance plans to take weeks to review prior authorization requests, leaving patients waiting. The process is often manual, requiring fax machines, phone calls, and paper submissions, meaning doctors cannot easily appeal these decisions.

The Improving Seniors' Timely Access to Care Act requires prior authorization decisions to be done faster, helping seniors get care more quickly. Most routinely approved prior authorization items and services will receive a real-time electronic response.

For nonroutinely approved items, doctors and patients will have clear expectations of how long they are going to need to wait for a response, allowing them to better coordinate their care.

Additionally, health insurance plans must begin to disclose data on how many prior authorizations they approve or deny, along with an analysis of how they made that decision.

Truthfully, I have seen many similar situations in the business I have been in my whole life. I am an automobile dealer, and when we are working on an owner's car under warranty, too often it is a negotiation with a manufacturer on what repairs we are able to do.

The manufacturer does their own time studies on how long they think it should take and what they think should be repaired. But oftentimes those time studies are on a brand new car or truck just off the assembly line. As we all know, living in western Pennsylvania, we have a lot of steep hills, and we go through really rough winters where there are a lot of things put on the road—salt and whatever else—that can corrode different parts once they are in operation.

It is the same story with insurance companies when we are doing covered auto body work. We have to give the insurance company the estimates before we ever touch a car or truck, and then continuously negotiate with them as we get into the tear-down of the vehicle and find other damage. We have to go back and get authorization to do that, and that holds up the process.

As much as people say, now, wait, wait, wait, don't compare cars and trucks and that warranty work to patients. You know what? It is the same thing. It is the same thing. You are denied access to care that you need today, not tomorrow, not some time in the future. There is no reason why you should have to wait for it, not in today's world, and not with the way we are able to improve all of this.

I know when I talked to Dr. BERA or Dr. BUCSHON and especially with Ms. DELBENE, we think: Why in the world are we working on old ways of getting answers as opposed to being able to get them today and get them more quickly?

I just think what we are doing makes sense. I would rely more on a technician who has expert experience than somebody who does time studies on something that isn't actually the duplicate of what we are looking to do.

This whole thing is about protecting our seniors, the people who have done the most for this generation and previous generations, who have really put their shoulders to the wheel and have never ever complained and always done what they think is best.

Why in the world would we make it harder for them to get the healthcare they deserve? Why? That makes absolutely no sense to any of us. This is not a red concern or a blue concern. It is all about red, white, and blue. It is about Americans. It is not Republicans or Democrats or Libertarians or anything else. It is about this body's obligation to come together on issues that are really critical.

There never should be this type of work that we have had to go through to get this done. And then all of a sudden last night, by the way, the CBO decided after 11 months to weigh in on how we would score this legislation. They waited until the 11th hour, and right after the 11th hour they pulled back what they had said they thought the cost was going to be.

I don't know how anybody runs a business like that.

I know if I give somebody an estimate or tell somebody something is going to be done at a certain time—and I know we make commitments to all of the people we represent, give them the right answer in the right time. Why make them wait for something that is so basic?

I know we always have this concern about fraud, waste, and abuse. My complaint really comes down to service. We can complain about a lot of things, but we cannot complain about what we owe our seniors.

We wrote and rewrote this bill over the course of the last several years to ensure it was as strong as possible, using everything that is available to us today to implement, to get answers quicker, not longer, not put people off, not tell them to wait in the waiting room, not tell them to stay on hold, but to get them an answer and get them the care that they need today.

□ 1230

Feedback is important. Honesty is more important. I know Ms. DELBENE and Dr. BERA and Dr. BUCSHON and so many of our colleagues agree the same way, and all the staff members that you mentioned.

This is not something that just happened very quickly and on the back of an envelope. This is something that a great deal of concern went into, a great deal of care went into, and a great deal of looking into went into.

So I am going to thank my colleagues, and I am going to ask everybody today, when this comes up for a vote, please vote for seniors. Please vote for all of those who have done so much for all of us. And take this opportunity to thank them in a way that really makes sense and, that is, by saying, you have played the game well; you have played the game long. You have done so much for all of us. Why don't we do something for all of you?

So I thank my colleague—it has been great—and all our colleagues for getting on board on this. It has been a really good example of how, when we actually work together on good policy and don't worry about the politics of it, amazing, amazing what can get done for the American people.

Mr. Speaker, I reserve the balance of my time.

Ms. DELBENE. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. CHU), my colleague on the Ways and Means Committee, another leader of this legislation.

Ms. CHU. Mr. Speaker, I rise in strong support of my colleague, Representative DELBENE's bill, the Improving Seniors' Timely Access to Care Act. I have heard from countless patients in my southern California district whose care has been delayed for weeks and, in some cases, outright denied because of countless barriers and archaic approval methods. And I have heard directly from physicians who are at their wits end, unable to provide the care they know will help their patients because of endless red tape.

The Improving Seniors' Timely Access to Care Act makes thoughtful and much-needed improvements to the Medicare system to correct these problems. The bill before us today will promote modernization of the prior authorization system to speed up approvals of routine procedures.

It moves the system of prior authorization into the 21st century, away from fax machines and toward electronic approval methods. By shortening the window by which insurance plans must respond to a prior authorization request, the bill will ensure patients get the care they need when they need it.

I urge my colleagues to support this important legislation.

Mr. KELLY of Pennsylvania. Mr. Speaker, I want to take a moment also to thank the Regulatory Relief Coalition because they have been working hand in hand with us trying to contact as many members as they can. And today is an example of when we work together, what we can get done.

Mr. Speaker, I present one of the doctors in our Doctors Caucus from North Carolina, Dr. MURPHY, to give his actually on-the-job, on-the-field experience of what it is like to try to work through this massive group of—I don't know what you call these people. They are hard to work with and they don't represent us. They do represent something else. I think we need to represent just our folks back home.

Mr. Speaker, I yield such time as he may consume to the gentleman from North Carolina (Mr. MURPHY).

Mr. MURPHY of North Carolina. Mr. Speaker, I thank Representatives DELBENE and KELLY for putting forth the timely Improving Seniors' Timely Access to Care Act.

Mr. Speaker, I would just like to explain to the public what pre-authorization means. I am a practicing physician, so if I order a test, I recommend a surgery, it then goes into a bucket at an insurance agency, and then we play the great waiting game. The patient is no longer in the office because we have no idea how long that waiting game is. It was put in and accepted for what I believe was a good cause. But as with many government programs, or institutions, or institutions of our bureaucracy in the private sector even, it is something that has gone bad and gone terribly wrong.

I may be waiting 2 or 3 or 4 weeks to speak with somebody who is not my peer. I am a surgeon. I may be speaking with a pediatrician or, even more, I might be speaking with a nurse practitioner who has no experience whatsoever in my field of study to get their approval of something that I know needs to happen. It is an absolutely antiquated system that does not work.

I am going to give you a couple of examples. Approximately 10 weeks ago, I saw a prostate cancer patient. There were two avenues to go on this: Either he needed to be operated on very quickly, or the cat was out of the bag, and he needed intensive chemotherapy quickly.

A week goes by, 2 weeks go by. What is that patient doing at home? He hasn't slept one wink because his entire future, his entire life, is then suspended in front of him.

It took 3 weeks, 3 weeks to get the study that every urologist in the country knew was necessary to get that answer. Yet, in the meantime, that patient has lost years, just in life as far as worry.

A second; one of my partners did a very complicated surgery on a patient. The patient was a bad diabetic; came in a week or two later with a wound infection. Fine, come in, get some intensive IV antibiotics. Try to get the patient out of the hospital because we know it is good to get patients out of the hospital when they don't need to be in the hospital.

He needed a certain oral antibiotic that was prescribed for him. It was denied. It was denied. It was denied. A week and a half later, he shows up in my office as an emergency. I have to send him over somewhat late in the afternoon, so that means he gets on the OR schedule at 10:00, 11:00, or 2 a.m., and has to have an abscess drained. And then he is in the hospital now another 2 weeks because he didn't get that antibiotic prescribed to him when he should have because it was denied, his authorization.

Mr. Speaker, I know the CBO score came in. I don't believe it. I have lived and breathed this for 30-plus years. I don't believe it. It doesn't pass the smell test. To come up at the last minute with this score, in my opinion, is erroneous and needs to be looked at again, because I look at the savings that we, as physicians, provide in knowing what is right for our patients in the moment versus some bureaucrat in an insurance company who is given the directive to deny, deny, deny, is not what we should be doing in medicine. Our medical system has become bankrupt and these pre-authorizations are part of it.

So I have a hard time going along with the CBO score of $16 billion because I don't believe it. This is what is right for patients. This is decades past the time when this should have been done.

I look at the doctors that I have worked with, and we are just plagued in clinic, because we know what we are going to recommend for our patients after years of study and work with patients is going to be possibly denied by someone who has no experience who has been told by insurance companies, deny, deny, and deny until they wear out the doctor and wear out the patient.

So, Mr. Speaker, this is a travesty, I believe, to not pass this bill. I also do not believe the CBO score, and I think it is a great injustice for our patients to be denied care because of this antiquated pre-authorization system.

Ms. DELBENE. Mr. Speaker, it is so important that we work with experts in the medical community to develop strong legislation, and we are incredibly fortunate to have as one of our coleads on this bill one of our doctors in Congress, so I want to thank him for all of his incredible work getting us to where we are today.

I yield 3 minutes to the gentleman from California (Mr. BERA).

Mr. BERA. Mr. Speaker, I want to first thank my colleague from the great State of Washington, Ms. DELBENE, as well as my good friend from Pennsylvania, Mr. KELLY, as well as my fellow doctor, Dr. BUCSHON.

This was how legislative processes should work. You identify a challenge, you work on it, you work on it in a bipartisan way. But you put the American patient first because that is what this it about at the end of the day. How do we give efficient, quality care to America's patients, and, in this case, America's seniors.

I have been practicing medicine going back to 1995. And yeah, I have used a fax machine back in 1995. This is about coming into the 21st century, modernizing the practice of medicine.

It is also about letting us do what we went to medical school for, what we did residency for. After 4 years of undergrad, 4 years of medical school, anywhere from 3 to 7 years and longer of residency training, doctors want to be doctors. They want to take care of their patients.

Yes, there is a role for prior authorization in limited cases. There is also a role to go back and retrospectively look at how care is being delivered. But what is happening today is a travesty. It wasn't the intention of prior authorization. It is a prior authorization process gone awry. And let me give you some examples.

When I talk to my former colleagues, the folks I went to medical school with, they spend up to 40 percent of their time on paperwork, on administrative burden, on doing things that don't enhance clinical care or enhance their ability to take care of patients.

We heard Dr. MURPHY talk about the delays in care. That adds costs, that adds time, and in some cases, it occasionally will potentially kill a patient. That isn't what this is about.

This is about providing America's seniors efficient care, reducing the burden, and allowing doctors to do what we went to medical school for, take care of patients.

Let's bring this into the 21st century, and let's start to put the patient central in American healthcare. And that is how we are going to actually lower costs of care, deliver better outcomes, and improve satisfaction.

We see a lot of doctors leaving the practice of medicine because of that administrative burden, the hassle factor. That doesn't improve care. That actually makes care worse.

So let's move into the 21st century. Let's deliver that care, and let's move forward.

This is a shining example of how Congress should work. If you think about it, 320-plus Members of Congress, in a bipartisan way, of the House, support this legislation. All of the doctors in Congress support this legislation. You have got Senate support of this legislation. Over 500 groups of my colleagues support this legislation. It is about good medicine. It is about taking care of the patients.

I also want to recognize my prior senior healthcare legislative assistant, Colleen Nguyen, who worked incredibly hard on this, as well as my current healthcare legislative assistant, Harsh Patel. As Congresswoman DELBENE pointed out, it is the staff that makes us look good.

Everybody should vote for this, and we should pass it unanimously.

Mr. KELLY of Pennsylvania. Mr. Speaker, I yield myself the balance of my time.

I know Dr. BERA is leaving the floor right now.

So often, when I am home and I am here, we always pick winners and losers and, somehow, that becomes the main objective of who won, who lost. So we are worried today about the score. It doesn't matter on the score because everybody wins on this. There is no loser on this.

And if we can't look to the people who have supported us our whole lives and have created opportunities that exist in this country on their backs, what in the world are we doing here?

Well, I can't tell you how much I appreciate the opportunity to be with Ms. DELBENE. This is incredible to get this done today.

I am urging every single Member to vote for this. Please throw out your scorecard and look at the picture in your wallet of who it is that parented you or grandparented you and say you know what, wouldn't it be nice to give them something back after they gave us their whole life? And let them have some peace of mind.

I don't think there is anything greater in your later years than peace of mind and being able to know that I am getting healthcare when I need it. I am not going to have to wait for somebody someplace else to determine whether I should get it.

So it has been a pleasure working with you. It has been a pleasure working with all of our colleagues. And for Dr. MARSHALL, who used to sit here with us but now is over in the senior area of this magnificent model—although, I think he is too young to be there. Now, I am sure my older Senators will say, hey, KELLY, please don't call us old. I won't. Let's just say the more seasoned Members.

But I am glad we can wrap this up on a really good note. I can't tell you how good I feel about this, that we can go

home and tell those people that we represent—I don't care how they vote. All I want them to know is we care about what they have done for us, and we are going to be able to supply them some peace of mind.

Mr. Speaker, I yield back the balance of my time.

□ 1245

Ms. DELBENE. Mr. Speaker, I think it is past time for us to help our seniors get timely care. It is past time to help our medical professionals, our doctors, our nurses, and others who are burdened with undue paperwork, to help them spend more time providing care. It is past time for us to move a strong piece of legislation that has strong bipartisan support.

I thank Chairman NEAL and everyone who has helped bring this legislation forward, folks on the Ways and Means Committee, including my colleague Mr. KELLY.

Mr. Speaker, I urge all of my colleagues to support this legislation, an incredible piece of work.

Mr. Speaker, I yield back the balance of my time.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, September 14, 2022.

MR. BLUMENAUER: Mr. Speaker, I am pleased to support this important legislation to protect seniors' access to care in the Medicare Advantage program.

As many of you know, I have been a longtime champion of Medicare Advantage, and it's enjoyed tremendous popularity in Oregon. I believe that the way traditional fee-for-service Medicare operates is not sustainable and that Medicare Advantage is one of the tools we can use to demonstrate how we can incentivize value.

But this is only possible when the program operates as intended. I have been deeply concerned about the reports of delays in care, not only from the Inspector General, but from the constituents that come into my office. For patients and their families, being told that you need to wait longer for care that your doctor tells you that you need is incredibly frustrating and frightening. There's no comfort to be found in the fact that your insurance company needs time to decide if your doctor is right. For providers, the burden of prior authorization is immense. And at a time where we consistently hear that our health care workers are facing incredible burnout and are leaving the profession in alarming rates, it's critical that we remove unnecessary processes.

There is no reason that patients should be waiting for medically appropriate care especially when we know that this can lead to worse outcomes. The fundamental promise of Medicare Advantage is undermined when people are delaying care, getting sicker, and ultimately costing Medicare more money.

The legislation we are taking up today is commonsense policy that moves us towards the goals of the program and protects our patients and providers from unnecessary roadblocks to care. I want to commend Congresswoman DelBene for her leadership on this issue and I look forward to supporting this bipartisan legislation.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Washington (Ms. DELBENE) that the House suspend the rules and pass the bill, H.R. 3173, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

PROVIDING FOR CONSIDERATION OF H.R. 302, PREVENTING A PATRONAGE SYSTEM ACT OF 2021; PROVIDING FOR CONSIDERATION OF H.R. 2988, WHISTLEBLOWER PROTECTION IMPROVEMENT ACT OF 2021; PROVIDING FOR CONSIDERATION OF H.R. 8326, ENSURING A FAIR AND ACCURATE CENSUS ACT; AND FOR OTHER PURPOSES

Mr. RASKIN. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 1339 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 1339

Resolved, That upon adoption of this resolution it shall be in order to consider in the House the bill (H.R. 302) to impose limits on excepting competitive service positions from the competitive service, and for other purposes. All points of order against consideration of the bill are waived. The amendment in the nature of a substitute recommended by the Committee on Oversight and Reform now printed in the bill shall be considered as adopted. The bill, as amended, shall be considered as read. All points of order against provisions in the bill, as amended, are waived. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto, to final passage without intervening motion except: (1) one hour of debate equally divided and controlled by the chair and ranking minority member of the Committee on Oversight and Reform or their respective designees; (2) the further amendment printed in part A of the report of the Committee on Rules accompanying this resolution, if offered by the Member designated in the report, which shall be in order without intervention of any point of order, shall be considered as read, shall be separately debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, and shall not be subject to a demand for division of the question; and (3) one motion to recommit.

SEC. 2. At any time after adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2988) to amend title 5, United States Code, to modify and enhance protections for Federal Government whistleblowers, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on Oversight and Reform or their respective designees. After general debate the bill shall be considered for amendment under the five-minute rule. The amendment in the nature of a substitute recommended by the Committee on Oversight and Reform now printed in the bill, modified by the amendment printed in part B of the report of the Committee on Rules accompanying this resolution, shall be considered as adopted in the House and in the Committee of the Whole. The bill, as amended, shall be considered as the original bill for the purpose of further amendment under the five-minute rule and shall be considered as read. All points of order against provisions in the bill, as amended, are waived.

SEC. 3. (a) No further amendment to the bill, as amended, shall be in order except those printed in part C of the report of the Committee on Rules accompanying this resolution considered pursuant to subsection (b) and amendments en bloc described in section 4 of this resolution.

(b) Each further amendment printed in part C of the report of the Committee on Rules not earlier considered as amendments en bloc pursuant to section 4 of this resolution shall be considered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole.

(c) All points of order against the further amendments printed in part C of the report of the Committee on Rules or amendments en bloc described in section 4 of this resolution are waived.

SEC. 4. It shall be in order at any time for the chair of the Committee on Oversight and Reform or her designee to offer amendments en bloc consisting of amendments printed in part C of the report of the Committee on Rules accompanying this resolution not earlier disposed of. Amendments en bloc offered pursuant to this section shall be considered as read, shall be debatable for 20 minutes equally divided and controlled by the chair and ranking minority member of the Committee on Oversight and Reform or their respective designees, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole.

SEC. 5. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill, as amended, to the House with such further amendments as may have been adopted. In the case of sundry further amendments reported from the Committee, the question of their adoption shall be put to the House en gros and without division of the question. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit.

SEC. 6. At any time after adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 8326) to amend title 13, United States Code, to improve the operations of the Bureau of the Census, and for other purposes. The first reading of the bill shall be dispensed with. All points of order against consideration of the bill are waived. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chair and ranking minority member of the Committee on Oversight and Reform or their respective designees. After general debate the bill shall be considered for amendment under the five-minute rule. In lieu of the amendment in the nature of a substitute recommended by the Committee on Oversight and Reform now printed in the bill, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 117-64, modified by the amendment printed in part D of the report of the Committee on Rules accompanying this resolution, shall be considered